Nos. 18-5218, 18-5219

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE DISTRICT OF COLUMBIA CIRCUIT**

PLANNED PARENTHOOD OF WISCONSIN, *et al.*,
*Plaintiffs-Appellants*,

v.

ALEX M. AZAR II, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, *et al.*,
*Defendants-Appellees*,

**On Appeal from the United States District Court**
**for the District of Columbia**

# BRIEF FOR AMICI CURIAE STATES OF CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, MAINE, MARYLAND, MASSACHUSETTS, MINNESOTA, NEW JERSEY, NEW MEXICO, NEW YORK, OREGON, PENNSYLVANIA, RHODE ISLAND, VERMONT, VIRGINIA, WASHINGTON, AND THE DISTRICT OF COLUMBIA IN SUPPORT OF APPELLANTS' MOTION FOR AN INJUNCTION PENDING APPEAL

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## INTERESTS OF AMICI CURIAE

The States of California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia as amici curiae have a compelling interest in protecting the health, well-being, and economic security of their residents. And the Title X family planning program, which serves four million women and men across the country, is instrumental in the States' efforts to secure those benefits for those who live within their borders. The federal program funds a wide array of critical public health services—including family planning counseling and access to all 18 FDA-approved contraceptive methods, pelvic exams, and screenings for high blood pressure, anemia, diabetes, sexually transmitted diseases and infections (STDs/STIs), and cervical and breast cancer. It is the linchpin of publicly funded family planning in the United States, the only national program, and a critical part of the States' efforts to deliver quality preventative care to its most vulnerable communities.[1]

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[1] Amici file this brief pursuant to Federal Rule of Appellate Procedure 29.

The Department of Health and Human Services' announcement that it is changing the criteria used to award Title X funds poses a direct threat to these interests. By giving preference to those providers that emphasize abstinence-only counseling and "natural family planning" over comprehensive family planning care, the new criteria undermine the Title X network of service providers and imperil the States' efforts to ensure that women get access to the most effective contraceptive methods, and the one that best meets their needs. The criteria also weaken the States' efforts to guarantee that women are provided complete information about their reproductive health. This in turn will lead to increased public health risks, such as the spread of communicable and preventable disease and unintended pregnancies. Ultimately, the States will bear the costs of any reductions in access to family planning services.

The States also share a strong interest in a fair and transparent regulatory process, as required by the Administrative Procedure Act. Amici depend on federal agencies to follow proper rulemaking procedures designed to ensure consideration of a broad array of interests, including those of state governments, before making important, and often complex, changes to agency rules. Agency action that ignores required rulemaking procedures or

standards for quality decision-making is not only illegal, but undercuts public trust in the process, policy changes, and the agencies themselves.

## ARGUMENT

### I. THIS COURT SHOULD MAINTAIN THE STATUS QUO WHILE IT CONSIDERS THE MERITS OF APPELLANTS' CHALLENGE

#### A. Absent an Injunction, HHS's New and Unlawful Alterations to the Grant Criteria—Implemented Without Notice and Comment—Will Disrupt the Title X Provider Network

HHS's unjustified change in criteria it uses in awarding Title X grants will undo many of the benefits that have accrued as a direct result of the current Title X program, especially for States which have invested in the Title X program and the network it has created within their borders.

The Title X funding structure anticipates collaboration between States and sub-grantees; thus, any change to the Title X grantees impacts the States. 42 C.F.R. § 59.5(a)(1). Indeed, Title X funds often flow initially to state agencies which then distribute the funds to sub-grantees. Over time, this partnership has ensured stability in the delivery of safety-net services that Title X was created to provide.[2] For example, California benefits from

[2] Adrienne Stith Butler & Ellen Wright Clayton, eds., Institute of Medicine, A Review of the HHS Family Planning Program: Mission, Management, and Measurement Results, at 133 (2009), https://www.ncbi.nlm.nih.gov/books/NBK215217/pdf/Bookshelf_NBK215217.pdf.

the largest Title X grant in the nation, which is used to fund healthcare providers throughout the State who deliver quality reproductive healthcare. California's Title X program collectively serves more than one million women, men, and teens annually—over 25% of all Title X patients nationwide—through 59 healthcare organizations that operate nearly 350 health centers and serve 37 of California's 58 counties. Similarly, other States rely on Title X to ensure that their residents receive medically-approved, comprehensive healthcare:

- Connecticut's Title X clinics served 40,440 patients in 2016. In 2010, Title X clinics prevented 9,500 unintended pregnancies, 14 cervical cancer cases, 29 gonorrhea cases, 400 chlamydia cases, and saved the federal and state government a net total of $80,942,000;
- Delaware's 55 Title X clinics served 19,132 patients in 2017;
- The District of Columbia's 34 Title X clinics served 39,984 women and 14,570 men over the past year;
- Illinois's 94 Title X clinics served 110,158 patients in 2016;
- Maryland's 73 Title X clinics served 73,675 patients in 2017;
- Massachusetts's 90 Title X clinics served 69,723 patients in the past year;
- New Jersey's 45 Title X clinics served 100,176 patients in 2016;

- New York's 178 Title X clinics served 305,464 patients in 2017;
- Pennsylvania's 191 Title X clinics served 198,825 patients in 2016;
- Rhode Island's 23 Title X clinics served 26,789 patients in 2017 with a variety of services including family planning visits (38,443), pregnancy tests (7,983), HIV tests (5,332), chlamydia tests (11,123), breast exams (6,080), and pap smears (3,072);
- Vermont's ten Title X clinics served 8,719 patients in 2014;
- Washington's 72 Title X clinics served 90,168 patients in 2016.

As this data makes clear, Title X is an integral part of the States' efforts to ensure that women and families receive high-quality healthcare. And the stability provided by consistent federal criteria on which Title X grants are awarded has proven to be crucial.

HHS's abrupt change to the Title X grant criteria puts these programs and the benefits that the States have accrued from them, at risk. Patient trust and provider quality take years to establish—gains that would vanish if funds are re-directed to clinics that prioritize abstinence only and other "natural family planning" methods. And those harms will be compounded by HHS's decision to end all multi-year grants, and to mandate the entire Title X national network to file new grant applications. The conventional

practice of awarding grants for a multi-year period eliminates a system-wide funding uncertainty for family planning programs. Allowing only a portion of Title X providers to compete for a grant at a given time, has contributed to the stability of the provider network and their ability to reach and serve vulnerable patients. In combination with the new, improper grant criteria, this decision will further undermine the States' network.

### B. Absent an Injunction, HHS's Unlawful Alterations to the Grant Criteria Will Impact the States' Most Vulnerable Residents

Disrupting the Title X network means disrupting the lives of Title X patients who rely on that network. For the past five decades, Title X clinics have served as the leading—and often only—family planning providers of services for low-income individuals, women of color, and rural communities. The vast majority of individuals who seek care from Title X clinics are low income: in California, 91% of Title X patients had incomes at or below 250% of the federal poverty level, and nearly 60% were uninsured in 2016.[3] Title X providers also serve a high proportion of

[3] Similarly, in New York, over 80% of Title X patients had incomes at or below 250% of the federal poverty level, and approximately 13% of all patients received their services at no cost. In Washington, 71% of Title X patients had incomes at or below 138% of the federal poverty level, and in Vermont, 47% of patients had incomes at or below 100% of the federal

patients of color. Nationwide, 21% of Title X patients self-identify as black or African-American and 32% as Hispanic or Latino/a, as compared to 13.3% and 17.6% of the nation, respectively. Ex. B (Coleman Decl.) ¶ 31; *see also* Ex. L (Harvey Decl.) ¶ 12.[4] And these clinics are especially critical in rural areas, where reproductive health access is limited by healthcare provider shortages, lack of transportation, and other factors. *See, e.g.* Ex. L (Harvey Decl.) ¶¶ 13-15. In seven rural California counties, a Title X clinic is the only publicly funded clinic offering a full range of contraceptive methods. Likewise, New Jersey's Title X clinics are the sole providers in some rural areas, and in New York, Title X clinics are some rural areas' only publicly funded clinics.

HHS's changes to the Title X funding criteria puts these clinics and their patient populations at risk. Among major concerns, the new criteria undermine these families' ability to obtain safe, effective, and continuous

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poverty level, while 77% of patients had incomes at or below 250% of the federal poverty level. In the District of Columbia, 85% of Title X patients had incomes at or below 250% of the federal poverty level.

[4] These statistics are consistent with amici States' Title X patient populations. For example, in the District of Columbia, more than 60% of Title X patients identified as black or African-American and 32% identified as Hispanic or Latino/a. In New York, 24% of Title X patients were black and 34% were Hispanic.

contraception. Current Title X providers work with their patients to ensure that they receive the contraceptive method that best fits their family planning needs, including any of the 18 FDA-approved contraceptive methods. And without these clinics, patients are likely to turn to less effective forms of birth control. That is because these clinics often reduce or eliminate the cost of the most effective forms of birth control.[5] Absent these price reductions, nearly half of women using hormonal birth control, implants or intrauterine devices (IUDs), or tubal ligation would switch to other methods, and 28% would use no contraception at all.[6]

Without access to reliable contraceptive methods, women will be at greater risk for unintended pregnancy, which in turn results in an increase in abortions. For example, a study of more than 9,000 women found that when

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[5] James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5, 6 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638200/pdf/nihms458012; Adam Sonfield et al., *Moving Forward: Family Planning in the Era of Health Reform*, Guttmacher Inst., at 10 (March 2014), https://www.guttmacher.org/sites/default/files/report_pdf/family-planning-and-health-reform.pdf.

[6] Jennifer J. Frost & Lawrence B. Finer., *Unintended Pregnancies Prevented by Publicly Funded Family Planning Services: Summary of Results and Estimation Formula*, Guttmacher Inst. (June 23, 2017), at 3, https://www.guttmacher.org/sites/default/files/pdfs/pubs/Guttmacher-Memo-on-Estimation-of-Unintended-Pregnancies-Prevented-June-2017.pdf.

the participants were offered the reversible contraceptive method of their choice at no cost, the number of abortions declined by 21%.[7] Study participants' abortion rate was less than half the national average.[8] Similarly, when Colorado implemented a family planning initiative, it found that offering free IUDs and implants led to dramatic declines in both birth and abortion rates, nearly 50% among teenagers and 38% among women without a high school education.[9] Indeed, in the absence of the publicly supported family planning services provided at Title X clinics, the "rates of unintended pregnancy, unplanned birth[10] and abortion in the United States

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[7] Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetricians & Gynecology 1291-1297 (Dec. 2012), http://journals.lww.com/greenjournal/Fulltext/2012/12000/Preventing_Unintended_Pregnancies_by_Providing.7.aspx; *see* Aparna Sundaram et al., *Contraceptive Failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth*, 49 Perspectives on Sexual and Reproductive Health, 7–16 (2017), https://www.guttmacher.org/sites/default/files/article_files/4900717.pdf (using any method of contraception greatly reduces a woman's risk of unintended pregnancy).

[8] Peipert et. al., *supra* n.7.

[9] *Taking the Unintended Out of Pregnancy: Colorado's Success with Long-Acting Reversible Contraception*, Colorado Dep't of Public Health and Environment, at 23, 26 (Jan. 2017), https://www.colorado.gov/pacific/sites/default/files/PSD_TitleX3_CFPI-Report.pdf.

[10] In the event that women carry to full term, the United States has the highest maternal mortality rate in the developed world—28 per 100,000 live

might have been 33% higher, and the rate of teen pregnancy might have been 30% higher."[11]

Access to effective contraception is also essential to women's broader health, financial independence, and social well-being. Contraceptive use can prevent preexisting health conditions from worsening—pregnancy may exacerbate conditions such as diabetes, hypertension, and heart disease—and new health problems from occurring.[12] Contraceptives can also provide other important health benefits, including decreasing the risk of certain ovarian and uterine cancers, and treating menstrual disorders and other

births, which is more than double the rate three decades ago. In the District of Columbia, the rate is 39 women per 100,000 live births—the highest in the Nation. For black mothers, this rate is three times that of white women. Rose L. Molina et al., *A Renewed Focus on Maternal Health in the United States*, 377 New Eng. J. Med. 1705 (Nov. 2017), https://www.nejm.org/doi/full/10.1056/NEJMp1709473.

[11] Publicly Funded Family Planning Services in the United States, Guttmacher Inst. (Sept. 2016), at 4, https://www.guttmacher.org/sites/default/files/factsheet/fb_contraceptive_serv_0.pdf.

[12] Hal C. Lawrence, Testimony of American Congress of Obstetricians and Gynecologists, submitted to the Committee on Preventive Services for Women, Institute of Medicine (2011), http://www.nationalacademies.org/hmd/~/media/8BA65BAF76894E9EB8C768C01C84380E.ashx.

menstrual-related health effects.[13] Unintended pregnancy is also associated with undue financial burdens and late prenatal care.[14] Further, ensuring that contraception is readily available to women who want it, without cost-sharing and with minimal practical barriers, promotes gender equity in healthcare services.[15]

Enabling women to reliably plan pregnancies also contributes to their educational and professional advancement. Women's use of contraceptives positively affects their education, labor force participation, and average earnings, narrowing the gender-based wage gap.[16] For example, in one 2011

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[13] Megan L. Kavanaugh & Ragnar Anderson, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, Guttmacher Inst., at 11 (July 2013), https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf

[14] Reproductive Life Planning to Reduce Unintended Pregnancy, Committee Opinion 654, American College of Obstetricians and Gynecologists, at 1 (Feb. 2016) https://journals.lww.com/greenjournal/Fulltext/2016/02000/Committee_Opinion_No__654___Reproductive_Life.53.aspx.

[15] Notably, women of child-bearing age spend 68% more in out-of-pocket healthcare costs than men, primarily owing to reproductive and gender-specific conditions. 155 Cong. Rec. S12, 021-02, 12,027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand); Clinical Preventive Services for Women: Closing the Gaps 12, Institute of Medicine (2011) https://www.nap.edu/read/13181/chapter/1.

[16] Adam Sonfield et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, Guttmacher Inst., at 7-9, 11-14 (2013),

study, women reported that access to contraception enabled them to take better care of themselves or their families (63%), support themselves financially (56%), stay in school or complete their education (51%), get or keep a job, or pursue a career (50%).[17] Restricting access to contraception would limit these opportunities and make it harder for women to succeed in the classroom, participate in the workforce, and contribute as taxpayers.

Finally, cutting funding to Title X clinics that provide access to effective methods of birth control will harm children. Pregnancies that occur too early or too late in a woman's life, or that are spaced too closely, increase the risk of harmful birth outcomes, including preterm birth, low birth weight, stillbirth, and early neonatal death.[18] According to the

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https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[17] Jennifer J. Frost & Laura Duberstein Lindberg, *Reasons for Using Contraception: Perspective of US Women Seeking Care at Specialized Family Planning Clinics*, 87 Contraception 4465, 465-472 (Apr. 2013), http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf.

[18] *See* p. 11 n.13 at 8; Amanda Wendt et al., *Impact of Increasing Inter-Pregnancy Interval on Maternal and Infant Health*, 26 (Supp. 1) Pediatric & Perinatal Epidemiology 239, 248 (2012), http://tinyurl.com/gnmvbxe; Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes*, 295 JAMA 1809, 1821 (2006); Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health*, 39 Stud. Fam. Plan. 18, 23-25 (2008).

American College of Obstetricians and Gynecologists, infants born as a result of unintended pregnancies are at greater risk of birth defects, low birth weight, and poor mental and physical functioning in early childhood.[19] Because the improvement in access to methods of family planning has lessened the incidence of these and other maladies, the CDC labeled it among the 10 great public health achievements of the 20th century.[20] HHS's new preference for clinics that prioritize abstinence-only and "historically underrepresented" methods of family planning will not improve family planning care but will instead represent a step backward.

Without an injunction, Title X clinics, such as appellants, will be at risk of losing crucial funding that is necessary to provide an array of services that benefit women and families across the country. The Planned Parenthood appellants and NFPRHA's members comprise 84% of the current Title X grantees, with Planned Parenthood specifically serving 41%

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[19] *See* p. 11 n.14.

[20] Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900-1999: Family Planning*, 48 Morbidity & Mortality Wkly. Rep. 1073 (1999); Ctrs. for Disease Control & Prevention, *A Vision for an Integrated State Health System: Challenges, Solutions and Opportunities* (Aug. 27, 2012), http://www.ncsl.org/portals/1/documents/health/JMonroePHI812.pdf.

of all Title X patients across the country.[21] Women's health clinics, like appellants', act as a "one stop shop" where a patient can seamlessly see medical providers, get screened and tested for disease, and access needed prescription or medical supplies, without having to travel offsite to a pharmacy, or an additional medical or lab testing facility. This service is particularly important for low-income patients served by Title X who may lack the time, money, or resources to take additional time off work or school or arrange for childcare.

Implementing the challenged grant criteria puts these patients and the numerous benefits they receive through Title X at serious risk. For example, the new criteria omit the requirement that Title X providers follow HHS's own clinical standards of care, the Quality Family Planning Guidelines—the gold standard of recommendations for providers on what to offer during a family planning visit and how to provide such services. By de-emphasizing FDA-approved contraceptive methods in favor of less effective strategies and removing all reference to the Quality Family Planning Guidelines, the

[21] Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics 2015*, Guttmacher Inst. (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

new criteria encourage and permit direct grants to health centers that do not provide women complete and comprehensive family planning care. Funding less-reliable applicants will reduce funding available for established, qualified family planning providers, such as those providing the numerous benefits outlined above.

### C. Absent an Injunction, HHS's Illegal Changes to Title X Will Undermine States' Ability to Ensure Accurate and Timely Healthcare

The amici States have a strong interest in ensuring not only women's continued access to the full range of reproductive healthcare, but also in safeguarding women's ability to obtain comprehensive and accurate information. In healthcare, information can "save lives," and enable people to act in "'their own best interest,'" *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566, 578 (2011). But, "'people will perceive their own best interests if only they are well enough informed.'" *Id.* at 578 ("'information is power'" and increased knowledge leads to "'better decisions'"). Specific to contraception, accurate information about comprehensive reproductive healthcare options allows women to take control of their most "intimate and personal choices . . . central to personal dignity and autonomy." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (plurality op.). The burdens that result from restricting access to or information about

reproductive healthcare, including information about contraception, often fall disproportionately on a state's most vulnerable residents, including low-income women and women of color. States know from experience that restricting access to reproductive healthcare information inescapably burdens the general public.

HHS's changes to the criteria used to award Title X grants threaten these interests. HHS's new preference for clinics that promote abstinence, and its elimination of any reference to contraception or medically-accepted family planning, will open the door to applications from less reliable providers, including those with no experience in providing family planning care or those focused on advocacy of their views at the expense of their patients' medical needs. And amici States have been witness to how these centers prevent women from accessing the critical information needed to make the right choices for themselves. For example, facilities known as "crisis pregnancy centers" are known to provide limited or no medical care, and often times give women incomplete information about healthcare options, directing women towards pregnancy over preventive family

planning care.[22] One study revealed that such centers routinely misstate medical facts, including several centers in California that birth control causes headaches and abortions cause breast cancer.[23] Yet the new Title X grant criteria improperly allow unreliable centers of this sort to now qualify and compete for grant funding.

Providing resources to these limited-service centers in lieu of qualified Title X clinics jeopardizes the health and lives of many women, especially low-income and other at-risk women. In the Title X context, if a family planning site does not offer complete information and access to the most

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[22] *Unmasking Fake Clinics: The Truth About Crisis Pregnancy Centers in California*, NARAL Pro-Choice California Foundation, at 2 (2010) (finding a "systematic pattern of exploitation," including that "[w]hile the majority of the centers advertised that they provide options counseling and accurate information to women seeking guidance, they did neither. Instead, many of these centers practiced manipulative counseling and provided medically inaccurate information."), https://www.sfcityattorney.org/wp-content/uploads/2015/08/Unmasking-Fake-Clinics-The-Truth-About-Crisis-Pregnancy-Centers-in-California-.pdf.

[23] *See* Robin Abcarian, *Going Undercover at Crisis Pregnancy Centers*, *L.A. Times* (May 1, 2015), http://www.latimes.com/local/abcarian/la-me-0501-abcarian-crisis-pregnancy-20150501-column.html; Minority Staff of H. Comm. on Gov't Reform, 109th Cong., False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers, at 7 (July 2006) (finding that 87% of clinics surveyed "provided false or misleading information") https://fedupburlington.files.wordpress.com/2011/07/congressional-report-cpcs.pdf.

effective contraceptive methods, patients in that community may never receive it.

### D. Absent an Injunction, the States' Public Health and Public Dollars Are at Risk

Implementing the new Title X grant criteria threatens the States' interest in public health and their public coffers. Title X clinics play a major role in the detection and early treatment of a range of STDs and other serious medical conditions.[24] Indeed, between 2006 and 2010, 18% of all women who were tested, treated, or received counseling for an STD did so at a Title X clinic, as did 14% of women tested for HIV and 10% of those that received a Pap test or pelvic exam.[25] These services provide measurable benefits to overall state public health; in 2010 alone, Title X clinics prevented an estimated 53,000 chlamydia infections, 8,800 gonorrhea

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[24] *See* p. 3 n.2 at 6; Joan M. Chow et al., *Comparison of Adherence to Chlamydia Screening Guidelines Among Title X Providers and Non-Title X Providers in the California Family Planning, Access, Care, and Treatment Program*, 21 J. of Women's Health 837 (Nov. 8, 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411333/pdf/jwh.2011.3376.pdf (A recent study concluded that in California, "only Title X providers were more likely to adhere to screening guidelines.").

[25] Kinsey Hasstedt, *Title X: An Essential Investment, Now More than Ever*, 16 Guttmacher Policy Review 14, 15 (Summer 2013), https://www.guttmacher.org/sites/default/files/article_files/gpr160314.pdf.

infections, 1,900 cases of cervical cancer and 1,100 cervical cancer deaths.[26] During public health crises, such as the Zika outbreak, Title X providers play an important role in providing contraceptive methods to prevent the transmission of the disease and collaborating with the CDC.[27] The new Title X grant criteria, if implemented, would undermine these public health benefits by funding less-qualified applicants that cannot provide medical assistance in a crisis.

Implementing the grant criteria will also impact the public fisc. Collectively, in 2010, publicly funded family planning services yielded $13.6 billion nationally in government savings, or $7.09 for every public dollar spent.[28] Nationally, 68% of unplanned births is paid for with public funds, and the average cost of an unintended pregnancy is $15,364, while the

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[26] Fact Sheet: Publicly Funded Family Planning Services in the United States, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/sites/default/files/factsheet/fb_contraceptive_serv_0.pdf.

[27] Ctrs. for Disease Control & Prevention, *The Importance of Pregnancy Planning in Areas with Active Zika Transmission*, (June 2, 2016), at 23, https://www.cdc.gov/zika/pdfs/postzap-familyplanning.pdf; *see also* Office of Population Affairs, U.S. Health & Human Servs. Dep't: Providing Family Planning Care for Non-Pregnant Women and Men of Reproductive Age in the Context of Zika (Nov. 2016), https://www.hhs.gov/opa/reproductive-health/zika/toolkit/index.html (providing a toolkit, based on CDC guidance, for Title X clinics).

[28] *See* p. 19 n.26 at 4.

cost of a miscarriage is $4,249. The most effective way to reduce costs associated with unintended pregnancy is to improve access to consistent, effective, and affordable contraception. Colorado's family planning initiative, which provides long-acting contraception at little or no cost to low-income residents, allowed the State to avoid almost $70 million in public assistance costs. Thus, facilitating access to crucial Title X services not only improves health, but also reduces amici States' healthcare costs. In turn, granting an interim injunction to maintain the current status quo ensures that these benefits are maintained.

### E. A Program-Wide Interim Injunction Best Serves the Public Interest

The challenged changes to the Title X grant criteria threaten vital family programs across the Nation, including in amici States. These unlawful changes to the Title X program require program-wide relief as an interim measure while this Court considers the merits of appellants' appeals.

Program-wide interim injunctive relief is the natural result here. First, a program-wide interim injunction best serves the public interest by preserving the continuation of the Title X program during the pendency of the appellate litigation. *See, e.g., University of Texas v. Camenisch*, 451 U.S. 390, 395 (1981) (an injunction is customarily granted to preserve the

relative positions of the parties); *District 50, United Mine Workers of Am. v. Int'l Union*, 412 F.2d 165, 168 (D.C. Cir. 1969). Preserving the status quo prevents irreparable harm to the amici States and their residents, who rely on the Title X program as it has been implemented for the last fifty years. Indeed, the public interest is especially important to the grant of preliminary relief in the context of a challenge to unlawful governmental policies. *See N. Mariana Islands v. United States*, 686 F.Supp.2d 7, 21 (D.D.C. 2009); *Cf. Scripps-Howard Radio v. F.C.C.*, 316 U.S. 4, 15 (1942); *see also Sampson v. Murray*, 415 U.S. 61, 69 n.15 (1974).

Second, appellants' lawsuit, brought under the APA, challenges "agency action" and seeks to "set aside" that agency action, i.e., the new funding criteria. 5 U.S.C. § 706. As such, an interim injunction maintaining the status quo is the accepted remedy where matters of national concern are implicated. *See, e.g. Nat'l Mining Ass'n v. U.S. Army Corps. of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998); *see also Earth Island Inst. v. Ruthenbeck*, 490 F.3d 687, 699 (9th Cir. 2007), *rev'd in part on other grounds*. What's more, even outside the APA context, a suit by a sole plaintiff may implicate an entire federal program, necessitating program-wide injunctive relief. *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 890 n.2 (1990); *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). Accordingly, this

remedy is appropriate in a suit challenging a single, program-wide governmental action where HHS considers applications in a nationwide competition for a fixed sum of federal dollars. *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979).

Here, where appellants challenge a program-wide agency action on appeal that threatens public health in amici States across the country, there is no reason to deviate from the normal course. A program-wide interim injunction to maintain the status quo should issue.

## CONCLUSION

The amici States join in asking the Court to grant appellants' motion for an injunction pending appeal.

Dated: July 31, 2018

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## CERTIFICATE OF SERVICE

Case Name: *Planned Parenthood v. Azar* No. **18-5218 and 18-5219**

I hereby certify that on this July 31, 2018, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

| Karli Eisenberg | */s/ Karli Eisenberg* |
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| Declarant | Signature |

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